Instructions for Completing Planned Home Birth Outcome Report

Objective:

To provide data including prenatal history, transfers, and perinatal complications for monitoring quality and outcomes of planned home births to Medicaid-covered women in Washington State.

General Instructions:

1. Complete all sections of the report.

2. Attach a separate page with comments as needed.

3. Submit the completed report with the HCFA-1500 Claim Form within 365 days of the birth for Medical Assistance Administration reimbursement. Reimbursement will not be made unless the form is complete.

4. Make a copy of the Planned Home Birth Outcome Report for your records. Mail a copy of the report to the designated quality assurance/quality improvement (QA/QI) organization and the HCFA-1500 claim form to MAA's Home Birth Program Manager (see Important Contacts section for addresses).

5. Make copies of the report to maintain a supply or write to MAA's Home Birth Program Manager for additional copies.

Note: Complete this form even if you transfer care of your client to another provider and are billing only for antepartum care.

Instructions for Completing
Planned Home Birth Outcome Report (cont.)

I. CLIENT IDENTIFICATION

1. Name
- Mother's full name-- last name, first name, and middle initial.

2. Mother's DOB
- Indicate the mother's date of birth with two digits for the month, two digits for the day, and four digits for the year (MMDDYY).

3. Mother's age at delivery
- Indicate the mother's age at the time of delivery.

4. Estimated Date of Delivery
- Indicate the estimated date of delivery using two digits for the month, two digits for the day, and four digits for the year.

5. Mother's race
- Indicate the mother's self-identified race as noted on the newborn's birth certificate.
- Check only one box.
- If other, specify in the space provided.

6. Baby's DOB
- Indicate the infant's date of birth with two digits for the month, two digits for the day, and four digits for the year.
- Check "unknown" if you complete the form before the birth (if the mother transfers from your care) or you do not know the infant's date of birth.
- Check "not applicable" if the pregnancy ended in spontaneous or therapeutic abortion.

7. Gestational age at delivery
- Indicate the gestational age of the infant at birth by the estimated date of delivery and by newborn exam.
- Check "unknown" if you complete the form before the birth (if the mother transfers from your care) or you do not know the gestational age.

8. Birthweight
- Write in the infant's weight at birth in grams, or in pounds and ounces.
- Check "unknown" if you complete the form before the birth (if the mother transfers from your care) or you do not know the infant's birth weight.

9. Infant sex

- Indicate the infant's gender.
- Check "unknown" if you complete the form before the birth (if the mother transfers from your care) or you do not know the infant's gender.

10. Place of birth

- Check only one box to indicate the place of birth:
  - ✓ Check "home" if the infant was born at home.
  - ✓ Check "birth center" if the infant was born in a birth center.
  - ✓ Check "hospital" if the infant was born in hospital.
  - ✓ Check "unknown" if you complete the form before the birth (if the mother transfers from your care) and you do not know the place of birth.
  - ✓ Check "other" and specify the place of birth if the infant was not born at home or in hospital.

11. Type of delivery

- Check only one box to indicate the type of delivery
  - ✓ Check "Sab" if the pregnancy ended in spontaneous abortion.
  - ✓ Check "Tab" if the pregnancy ended in therapeutic abortion.
  - ✓ Check "NSVD" if the birth was a normal spontaneous vaginal delivery.
  - ✓ Check "Forceps" if the mother was transferred to hospital for a forceps delivery.
  - ✓ Check "Vacuum" if the mother was transferred to hospital for a vacuum extraction.
  - ✓ Check "Cesarean" if the mother was transferred to hospital for cesarean section.
  - ✓ Check "Unknown" if the mother transferred care and you do not know the type of delivery.

II. MATERNITY CARE

12. Gravida

- Indicate the number of times the woman has been pregnant.

13. Para

- Indicate the number of times the woman has had a live birth (>20 weeks gestation).

14. Weeks gestation at first prenatal visit with home birth provider

- Indicate the estimated number of weeks gestation at the time the woman initiated prenatal care with you. (Note: this may not be the same as the number of weeks gestation at the time the woman entered prenatal care.)

15. Prior prenatal care

- Check "yes" or "no" to indicate whether or not the woman had prior prenatal care with another provider prior to initiating care with you. Check "unknown" if you do not know whether or not the woman had prior prenatal care.

16. Total number of visits with home birth provider

- Indicate the number of prenatal visits the woman had <u>while in your care.</u>

III. PERINATAL COMPLICATIONS

Maternal Complications in Past Pregnancies

- For each complication listed, check either "Yes," "No," or "Don't Know" to indicate whether the woman had that complication in her obstetric history.
- If requested, indicate the number of weeks gestation at which the event occurred.
- Explain any "yes" or "don't know" answers in the space provided; attach additional pages as needed.
- If an item is marked with an asterisk (*) indicate whether or not you submitted a bill to MAA for home birth for the current pregnancy.

Maternal Complications This Pregnancy

- For each complication listed, check either "Yes" or "No" to indicate whether the woman had that complication.
- If the woman was admitted or readmitted to a hospital within the first 7 days of birth, indicate the hospital length of stay in days or weeks.
- If estimated blood loss was more than 500cc, write in the amount.
- Write in "Other" unlisted complications if experienced by the mother.
- Explain any "Yes" or "Don't Know" answers in the space provided; attach additional pages as needed.
- If an item is marked with an asterisk (*) indicate whether or not you submitted a bill to MAA for home birth for the current pregnancy.

Neonatal Complications

- For each complication listed, check either "Yes," "No," or "Don't Know" to indicate whether the infant had that complication.
- If the newborn was admitted or readmitted to a hospital within the first 7 days of birth, indicate the hospital length of stay in days or weeks.
- If the newborn was admitted or readmitted to a NICU (neonatal intensive care unit) within the first 7 days of birth, indicate the hospital length of stay in days or weeks.
- Write in "Other" unlisted complications experienced by the infant.
- Explain any "yes" or "don't know" answers in the space provided; attach additional pages as needed.

IV. CONSULTATIONS, REFERRALS AND TRANSFERS

Definitions:

Referral - The process by which the home birth provider directs the client to a physician for management (examination and/or treatment) of a particular problem or aspect of the client's care.

Consultation - The process whereby the home birth provider, who maintains primary management responsibility for the woman's care, seeks the advice or opinion of a physician (MD or DO) or ARNP on clinical issues that are patient-specific. These discussions may occur in person, by electronic communication, or by telephone.

Complete one row of the table for <u>each</u> time you consulted with, or referred the woman to, another provider for <u>pregnancy-related</u> reasons.

Date
Indicate the date of the consultation, referral or transfer with two digits for the month, two digits for the day, and four digits for the year.

Timing of Consultation, Referral or Transfer

- Indicate when the consultation or transfer took place and for which patient (mother or newborn) by checking the appropriate box using the following definitions:

  - ✓ ANTEPARTUM (AP) refers to the mother's care prior to the onset of labor.
  - ✓ INTRAPARTUM (IP) refers to the mother's care in the home any time after the onset of labor, up to and including the delivery of the placenta.
  - ✓ POSTPARTUM (PP) refers to the mother's care in the first 7 days postpartum.
  - ✓ NEWBORN (NB) refers to the infant's care in the first 7 days postpartum.

- If AP or IP, indicate the gestational age in weeks. If PP or NB indicate the number of days post-partum.

Type of Provider
In the space provided, write the number that corresponds to the type of provider who consulted with you, or assumed the woman's care (1=MD; 2=DO; 3=ARNP; 4=Unknown; 5=Other). If '5' (other) please specify the type of provider in the space provided.

Reason for Consultation
Refer to the attached document "Consultation, Referral and Transfer Code List." Find the section (Antepartum, Intrapartum, Postpartum, or Newborn) that corresponds to the period when the consultation or transfer took place. Choose the number in that section that corresponds to the reason for the consultation or transfer. Write this number in the space provided. If you choose the number for "other," specify the reason for consultation or transfer in the space provided. Attach a separate page to explain as needed.

Management Plan After Consultation
In the space provided, write the number that corresponds to the outcome of the consultation or transfer.

1=Telephone or electronic consult only;
2 = Referral for examination and/or treatment with return to home birth provider;
3 = Co-management care by home birth provider and consulting provider;
4 = Temporary transfer of care to another provider with return to home birth provider for follow-up;
5 = Permanent transfer of care to another provider).
If '3' or '4', indicate when the co-management or transfer took place in weeks gestation.

Was Transport Emergent?

Was there an emergent transport of the client? Check one box "yes", "no" or "N/A" to indicate whether there was an emergent transport at the time of consultation or transfer. Check "not applicable" if the consultation, referral or transfer did not result in maternal or infant transport.